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Queensland Government
Queensland Health

Policy Identifier:
23360

QUEENSLAND HEALTH POLICY STATEMENT:
Incident Management Policy

10 June 2004

Policy Title	**Queensland Health Incident Management Policy**
Policy Statement	All incidents, clinical and non-clinical, shall be managed within Queensland Health's Integrated Risk Management Framework for Clinical and Corporate Services (2002), according to this statewide policy and instruction. Queensland Health Districts, Statewide Services and Corporate Office are required to adopt and implement this statewide incident management policy. This policy requires managers to establish and maintain governance and management structures and accountabilities that manage, report, investigate and analyse incidents and near misses. It is mandatory to report and manage sentinel events and events with very high and extreme risk rating according to this policy. All employees of Queensland Health must be aware of and comply with this policy and instruction.
Policy scope	This policy covers all incidents, clinical and non-clinical, including "workplace incidents" as defined in the *Workplace Health and Safety Act 1995*. This policy focuses on potential and actual incidents that have or are likely to have very high or extreme risk rating.
Aims	To improve safety To reduce risk To learn from underlying causes of incidents and near misses and to implement systems to reduce the likelihood of recurrence
Principles	The following principles underpin the Queensland Health Incident Management Policy and shall be reflected in managing incidents at all levels. ***1. Duty of care*** Queensland Health and its staff have a duty to take reasonable care to avoid causing harm to patients, visitors, employees and contractors.

Sponsor: Deputy Director-General, Policy and Outcomes
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Principle 4 of Queensland Health's Code of Conduct (2002) requires *employees to take reasonable care to avoid causing harm to themselves or other people.*

Clinicians and managers have an ethical responsibility to maintain honest communication with patients and their support person, even when things go wrong. The Open Disclosure Standard procedures are to be followed[1].

2. Focus on system improvement
Most incidents and near misses are caused by a chain of events and system failures, not by an individual. Analysis and investigations are to focus on improving systems of care and shall be reviewed for their effectiveness.

3. Part of integrated risk management framework
Investigation of clinical and non-clinical incidents is to be conducted through processes that focus on the management of risk according to Queensland Health's Integrated Risk Management Policy.

4. Effective governance and management
Incident management is an essential part of good governance. It is a management tool and relies on a system of accountability.

Managers authorise, establish and actively maintain the incident management structure and system. Managers resource, support and encourage staff participation.

5. Consistent with Queensland Health's legal obligations
Incidents are reported, investigated and analysed according to statutory obligations and requirements (*see Legislation and Associated documentation p 4)*, procedural fairness and natural justice.

Reporting and investigation of certain incidents is a legal obligation for executives and managers in Queensland Health.

If incident management systems fail due to reasonable fear of adverse consequences of disclosure of information, one option is to pursue statutory protection or qualified privilege for a committee, under s31 of the *Health Services Act* (see p15).

6. Matches service capability
The incident management model is flexible to meet the different service configurations/capability around the State and local circumstances.

[1] *Open Disclosure Standard – a national standard for open communication in public and private hospitals, following an adverse event in healthcare* Australian Council for Safety and Quality in Health Care, July 2003

Queensland Government
Queensland Health

QUEENSLAND HEALTH INSTRUCTION
To Policy Statement 23360

Policy Title	**Queensland Health Incident Management Policy**
Scope and Application	All Queensland Health employees (permanent, temporary and casual), its agents, Visiting Medical Officers and other partners in care, contractors, consultants and volunteers.
Effective date	
Supersedes	New policy
Compliance	Incident Management is applicable to all Queensland Health services including Health Service Districts, Statewide Services and Corporate Office. All services are required to adopt and implement the endorsed systematic approach to risk management including incident management.
Review Cycle and Responsibilities	The Integrated Risk Management Program will review this policy within 12 months from the date of issue.

Legislation and Associated Documentation	*Queensland Acts* Child Protection Act 1999 Civil Liability Act 2003 Crime & Misconduct Act 2001 Coroners Act 2003 Electrical Safety Act 2002 Dangerous Goods Safety Management Act 2001 Freedom of Information Act 1992 Health Act 1937 Health Services Act 1991 Mental Health Act 2000 Personal Injuries Proceedings Act 2002 Public Safety Preservation Act 1986 Public Sector Ethics Act 1994 Public Service Act 1996 Whistleblowers Protection Act 1994 Workplace Health and Safety Act 1995 Workers Compensation and Rehabilitation Act 2003 *Policy and standards (Queensland Health)* including: Code of Conduct 2000 Complaints Management 2002 (Policy number 15184) Information Standard No 42A Information Privacy for Queensland Department of Health 2001 Informed Consent for Invasive Procedures 2002 (Policy number 14025) Integrated Risk Management for Clinical and Corporate Services Program – Guidance Document 2002 Integrated Risk Management 2002 (Policy number 13355) Policy Statement and Guidelines on the Treatment and Management of Abuse and Neglect of Children and Young People (0-18years) 2003 Public Patients Charter 2003 (*Your Rights and Responsibilities* - Making the most of a visit to your health service) Queensland Health Disaster Plan 2002 Queensland Health WorkCover Claims Management Guidelines 2002 IRM 3.1-2 Workplace Harassment – Standards of Appropriate and Ethical Behaviour in the Workplace IRM 3.1-4 Policy and Procedures for the management of public interest disclosure in accordance with the WPA 1994: 2000 IRM 3.1-5 Official Misconduct – requirements and process for reporting 2002 IRM 3 2-1 Workplace Health and Safety Policy 2000 (outlines systems for the management of incidents related to health and safety events) and Workplace Health and Safety Management Plan 1999 IRM 3.8-3 January 2003 Indemnity for Employees and Other Persons (Excluding Medication Practitioners) – Health Service Districts IRM 3.8-4 December 2002 Indemnity for Queensland Health and Other Approved Medical Practitioners *Other* Open Disclosure Standard – a national standard for open communication in public and private hospitals, following an adverse event in healthcare Australian Council for Safety and Quality in Health Care, July 2003
Corporate Office file	1236-0355-007
Further information	Contact the Principal Project Officer Incident Management, Integrated Risk Management Program, phone (07) 3234 1724

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Incident categories

In this policy, an incident is defined as *an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/ or a complaint, loss or damage.*

Incidents include those also defined in legislation including:

The *Workplace Health and Safety Act 1995* defines "workplace incident" as

- *an incident resulting in a person suffering a work injury; or*
- *a work caused illness; or*
- *a dangerous event; or*
- *another matter decided by the Minister to be a workplace incident.*

The *Personal Injuries Proceedings Act 2002* defines "incident" *in relation to personal injury, means the accident, or other act, omission or circumstance, alleged to have caused all or part of the personal injury.*

Two (2) categories of incidents are identified in this policy:

1. Potential – that is a hazardous situation that is detected prior to the patient, customer, client, consumer or staff being harmed this could include near misses
2. Actual – including adverse and serious adverse incidents

Incidents can be risk evaluated and rated by considering likelihood of occurrence and severity of consequences. **This policy focuses on potential and actual incidents that have or are likely to have very high or extreme risk rating (see Appendix 1).**

A sentinel event is an event that signals that something serious or sentinel has occurred and warrants in depth investigation.

Sentinel event list

Where a sentinel event occurs, it must be immediately reported, then investigated, actioned and communicated in accordance with the incident management model contained in this policy.

Queensland Health has deemed the following actual incidents as sentinel events:

	1. Surgery/procedure on the wrong patient/wrong body part 2. Deaths including[2]: (a) suicide of a patient (b) death of a patient as a direct and immediate result of medication error (c) death of a patient during inter-hospital transfer (d) direct maternal death (e) sudden and unexpected death of an infant associated with labour or delivery (f) unexpected death of a patient during surgery (g) unexpected death of a patient 3. Haemolytic blood transfusion reaction resulting from ABO incompatibility 4. Instrument or other materials inadvertently left in body cavity or operation wound following a procedure 5. Intravascular gas embolism resulting in death or neurological damage 6. Infant discharged to wrong family 7. Death of an employee during the course of their duties **Mental health specific:** 8. Suicide or unexpected death in respect of: • Any patient (inpatient or community) of a mental health service. • Any person who has been in contact with a mental health service or emergency department within the 7 days preceding the incident. 9. Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness 10. Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness.
Incident management model	Queensland Health's model for incident management includes nine (9) elements: • Prevention • Incident identification • Classification/ prioritisation • Reporting and recording • Patient and staff care/ management • Analysis/investigation • Action • Feedback • Communication **PREVENTION** Managers shall develop and maintain a strong safety culture in every service/ facility. Examples of a safety-first culture include: • Clinical guidelines & use of evidence-based practice

[2] Note a number of these sentinel events are also "reportable deaths" under the *Coroners Act 2003 s8(3)*.

- Credentials and clinical privileges
- Emergency procedures
- Falls prevention
- Fire safety procedures
- Healthcare associated infection management
- Informed consent
- Medication management system
- Occupational violence management
- Patient and staff safe safety handling programs
- Patient identification systems and procedures
- Pressure ulcer and wound prevention
- Risk reporting
- Staff training in understanding human error and patient safety
- Workplace health and safety committee, representatives and officers.

INCIDENT IDENTIFICATION

Incidents are identified in many ways, for example:

- Audit and peer review activities/reports
- Complaints
- Coroners' reports
- Death audits
- Equipment failure reports
- Food poisoning reports
- Hazard identification reports
- Health Rights Commission Annual Reports and Investigation Reports to service providers
- Infection rates
- Information security breach
- Loss of property
- Medication chart review
- Medico-legal requests and/or notifications of potential liability
- Self reporting (staff)
- WorkCover Claims
- Workplace Health and Safety checklist reports
- Workplace Health and Safety incident reporting

CLASSIFICATION/ PRIORITISATION

Incidents are prioritised according to their risk rating: severity of consequences and likelihood of reoccurring (see Appendix 1). This determines the urgency of response.

Incidents are classified by type e.g similar events such as falls, medication error.

The first priority in dealing with an incident is to respond by taking immediate action to prevent further harm, rectify or contain the situation, and to assess the risk.

The severity of an incident should be assessed for the level of risk being

[3] Non-accidental injury of a serious and permanent nature to the patient or another person caused by the patient
[4] Expected to be available after July 2004

faced at that time. This is done by the first person to detect the incident, by asking:

- How much harm has been caused?
- What are the consequences of that harm?
- What is the likelihood of the risk continuing and causing harm or further harm?

Assessment of the incident should be discussed with the line manager/ supervisor.

Full risk analysis should be conducted during the investigation phase.

In carrying out this assessment, reference can be made to the Integrated Risk Management Guidance Document and the Risk Matrix and consequences and likelihood table (Appendix 1).

REPORTING AND RECORDING

Locally, there should be a formal, documented process to guide how an incident will be reported. This information must be readily available to all employees and agents in a user-friendly format.

All incidents must be reported. These should be reported locally, according to the procedures established by managers at the local level.

Incidents with a very high and extreme risk rating should be reported to the appropriate line management.

The requirements of this policy do not remove Queensland Health staff's duty to meet statutory reporting requirements, for example obligations contained in the *Coroners Act*, *Crime and Misconduct Act* and IRM 3.1.5 and the *Workplace Health and Safety Act*.

Reporting sentinel events
The line manager must report sentinel events to the District Manager, State Manager, and relevant Corporate Office Branch Executive or Director of Mental Health **immediately**.

The District Manager, State Manager or relevant Corporate Office Branch Executive is required to notify the Director-General via the Secretariat, Risk Management Advisory Group **immediately**, using the Sentinel Event Notification Report template (see Appendix 2).

See Appendix 3 for a flow chart of the high level management of sentinel events.

Reporting potential and actual incidents that have or are likely to have very high or extreme risk rating
Potential or actual incidents rated as very high to extreme must be reported to the District Manager, State Manager or relevant Corporate Office Branch Executive **within 24 hours**.

Mental Health Specific Incidents
In addition to reporting suicides and unexpected deaths of patients of mental health services the following mental health incidents must also be **reported to the Director of Mental Health (DMH) immediately:**

Non-accidental injury of a serious and permanent nature[3] in respect of:

- Any patient (inpatient or community) of a mental health service.
- Any person who has been in contact with a mental health service or emergency department within the 7 days preceding the incident.

Absence without approval or other serious adverse incident in relation to the following patients:

- Persons of Special Notification.
- Classified Patients.
- All inpatients within a medium and high secure setting.
- High risk patients.

Reporting requirements – local

Incidents shall be reported by staff when they first become aware of the incident e.g. from a complaint or informal communication. It is important to note all staff are required to report an incident even if they believe the incident has been previously reported by another staff member.

All incidents shall be reported on an incident report form using the agreed Queensland Health data definitions and data elements[4].

Each District Manager, State Manager or relevant Corporate Office Executive shall maintain a comprehensive register of all reported incidents in their accountability area

See p.11 for requirements about providing feedback to those who have reported an incident.

The Secretariat, Risk Management Advisory Committee, shall maintain the statewide Register of Notified Sentinel Events and a register of Annual Reports received on incidents and incoming aggregated data.

The following information must be included in an incident report:

- a description of the incident
- date and time of incident
- name of the person involved in the incident
- patient's UR number (where applicable)
- severity (see pp.7-8)
- type (see pp 7-8)
- immediate action taken to prevent further harm, rectify or to contain the situation

The name and details of the person reporting the event is mandatory for the following incidents:

- involving staff (i.e. a staff member is injured)
- that may lead to litigation where indemnity may be sought by staff involved in the incident (see Industrial Relations Manuals 3.8-3 and 3.8-4)
- which relate to research or clinical trials
- that are reportable in law (such as reportable to the Coroner).

For other incidents, anonymous reporting is a local management decision.

Reporting requirements – state (see p.12 Communication)

PATIENT AND STAFF CARE/MANAGEMENT

The first priority is prompt care and support of the people involved, removal of danger and prevention of further harm. This is called immediate action.

The reporting person and where possible the line manager/ supervisor are responsible for immediate action that assists to bring the situation under control.

Patients, their carers and involved staff may need considerable support after experiencing an adverse event. A care plan is also required. The Open Disclosure Standard and procedures are to be followed (see p.15).

When harm has occurred, an expression of regret should be provided to the patient following the Open Disclosure Standard and consistent with the *Civil Liability Act* (CLA) statutory requirements.

Secondary action (medium term) and longer-term management of the incident occur during the investigation and action phases.

INCIDENT ANALYSIS/ INVESTIGATION

Locally, there should be a formal, documented process to guide how an incident will be managed and the level of analysis/ investigation required.

Incidents should be investigated and analysed according to their potential/ actual risk rating, level of harm caused and within the available resources

The line manager should determine the appropriate investigation agency and process. Investigation of certain incidents must meet the relevant statutory requirements including the *Coroners Act*, *Crime and Misconduct Act, Workplace Health and Safety Act,* and the *Health Services Act*. For example, if initial analysis/ investigation of the incident points to an intentionally unsafe act, the investigation/ analysis should cease and be reported to the District Manager, State Manager or Corporate Office Branch Executive in accordance with IRM 3.1-5 for appropriate administrative action.

In general, the incident analysis process includes

- Commissioning of a team, including external agencies if a statutory requirement
- Review of the incident report/s and other information at hand
- Use of tools to determine the sequence of events, contributory factors, probable causes and risk identification
- Analysis of risk using the Integrated Risk Management Guidance Document and the example risk classification and prioritisation table (Appendix 1)
- Identification of corrective action
- Identification of timelines and person/s responsible for corrective actions
- Preparation of a report including a corrective action plan
- Authorisation of recommended corrective actions by the District Manager, State Manager or relevant Corporate Office Branch Executive

The following mandatory requirements are to be used for investigating sentinel events:

and reported on the local Risk Register according to the Integrated Risk Management Policy and Guidance Document.

The District Manager, State Manager or relevant Corporate Office Branch Executive is responsible for reviewing local implementation of this policy and reporting compliance as required.

COMMUNICATION

Lessons learned locally from incident management, especially those incidents with very high to extreme risk rating, are to be communicated throughout Queensland Health, to reduce the likelihood of recurrence and monitor trends.

Communication must meet the relevant statutory requirements for example relating to the *Coroners Act, Crime and Misconduct Act, Workplace Health and Safety Act, Health Act* and the *Mental Health Act*.

The District Manager, State Manager or Corporate Office Branch Executive shall provide an annual report to the Director-General via the Secretariat, Risk Management Advisory Committee by 30 June on:

- Actions implemented regarding previously notified sentinel events
- Actions implemented regarding potential and actual incidents that have or are likely to have very high or extreme risk rating.

The Committee may request reports on a more urgent basis.

RESPONSIBILITIES AND ACCOUNTABILITIES

Incident management is the responsibility of everyone in the organisation. Employees shall be trained in and supported to apply this policy in their workplace.

Director-General	Provides leadership, strategic direction and ensures alignment with Whole-of-Government priorities. Accountable for providing leadership and ensuring that systems are in place that support good governance structures and enable efficient and effective management of the health care system and provide assurance that public confidence is maintained. Responsible for the operation of the Department that includes the establishment and maintenance of suitable systems of internal control and risk management.
Deputy Director-General, Policy and Outcomes	Provides leadership and strategic oversight in the development of policy and planning, information and business management reforms and capital programs. Responsible for the overall development and implementation of the Integrated Risk Management Policy and Framework and related policies and standards including the Queensland Health Incident Management Policy. Monitors and reviews statewide implementation of this policy.
General Manager, Health Services	Provides leadership and strategic oversight in relation to the delivery of statewide health services. Responsible for the overall implementation of risk management strategies including the Queensland Health Incident Management Policy within the

	Health Services Division and ensures that line management accountability is effective and that reporting across the Division occurs as part of core business.
Chief Health Officer	Provides high level medical advice to the Minister and the Director-General on health issues, especially on standards, quality, ethics and research issues.
Risk Management Coordinator	Responsible for providing the Secretariat to the Risk Management Advisory Committee. Responsible for maintaining the statewide Sentinel Event Notification Register and a register of Annual Reports received on incidents and incoming aggregated data.
Risk Management Advisory Committee	Responsible for receiving, analysing and monitoring notifications of Sentinel Events and trending of incidents in Queensland Health. Responsible for reporting incidents, trends and risks to the Director-General or delegate.
Director, Audit and Operational Review Branch	Responsible for Queensland Health's statewide Crime and Misconduct Commission liaison role and the investigation of alleged official misconduct. Maintains an investigations and whistleblowers database and monitors and reports on systemic issues and trends.
Zonal Managers	Responsible for monitoring the implementation of the incident management policy in Districts within the Zone. Responsible for monitoring compliance with mandatory incident reporting requirements.
District Managers, State Managers of Public Health Services, Pathology and Scientific Services, Statewide and non-Government Services, Information Services, Corporate Office, Branch Executives	Responsible for implementation of the incident management policy within their area of responsibility This includes to: ▪ Establish, endorse and maintain an effective local governance framework and system of accountability ▪ Ensure incident reporting meets statutory requirements ▪ Ensure staff training and compliance ▪ Ensure adequate resourcing to implement corrective actions ▪ Ensure corrective actions address very high and extreme risks and are implemented in a timely manner ▪ Provide mandatory reports ▪ Maintain risk and incident registers ▪ Provide information on request and report trends at least annually ▪ Monitor and review policy implementation within their area of responsibility ▪ Contribute to communication about risks and lessons learnt through Queensland Health
Managers/ supervisors	Responsible for implementation of the incident management policy within their area of responsibility. This includes to: • Ensure staff are aware of and comply with this policy • Develop local procedures for the reporting, investigation and management of incidents according to the local governance framework and system of accountability • Ensure that the immediate management of all incidents is appropriate, complies with the Open Disclosure Standard and aimed at reducing impact and ensuring containment • Ensure that incidents are reported and graded according to the Integrated Risk Management Analysis Matrix and that incidents are subjected to an appropriate level of analysis and review commensurate

- Use of a team, independent of the incident
- Analysis, commencing within seven (7) working days after the incident
- The root cause analysis investigation tool must be used
- Teams should be commissioned by the District Manager, State Manager or relevant Corporate Office Branch Executive
- At least one member of the team must be trained in using the root cause analysis tool and process
- A report must be provided to the District Manager, State Manager or relevant Corporate Office Branch Executive within 45 days of commencement of investigation

See Appendix 3 for a flow chart of the management of sentinel events.

ACTION

Actions are identified through investigating the underlying causes of incidents and near misses and are documented in a report for the District Manager, State Manager or Corporate Office Branch Executive.

The District Manager, State Manager or Corporate Office Branch Executive shall nominate a person, unit or committee to receive investigation reports and authorise and resource this entity to implement authorised actions.

Corrective actions for potential or actual incidents rated as very high to extreme, including sentinel events, must be endorsed by the District Manager, State Manager or relevant Corporate Office Branch Executive. Actions should be limited to a maximum of three, aiming for two strong and one intermediate action (see p 13).

The corrective action plan should be included for priority implementation within the service/ quality improvement plan/ cycle.

FEEDBACK

Feedback about immediate actions already taken, the investigation and actions to be taken, must be provided to those harmed by incidents and those involved in incident response and management in a timely manner. The person responsible for providing feedback is identified through local procedures

The Open Disclosure Standard must be used as the framework for communication with the patient and their support person/s and with involved staff. Sections 10.3-10.5 of the Standard provide guidance on the timing of disclosure as well as who will make the disclosure and what will be disclosed.

Feedback must meet the relevant statutory requirements for example relating to the *Coroners Act*, *Crime and Misconduct Act* and *Workplace Health and Safety Act.*

Local incident management information should be aggregated and reviewed by the District Manager, State Manager and Corporate Office Branch Executive. Actions aimed at preventing similar incidents from occurring will be implemented, monitored and reviewed through the service/ quality improvement plan/ cycle.

Identified risks from analysing incidents and near misses must be recorded

	with the level of risk • Ensure that improvement strategies are developed and implemented within timeframes agreed by local management • Ensure that all improvement strategies are monitored and reviewed for efficiency, effectiveness and appropriateness • Ensure feedback and communication between the local designated area of responsibility for incident monitoring and analysis and those providing direct patient care
Contact officer	Each Health Service District, Statewide Service and Corporate Office Branch Executive has a nominated contact officer to receive information regarding this policy and distribute to relevant staff in their area
Employees/ agents	Employees and agents are required to: • Be aware of and comply with this policy • Report incidents including near misses to a designated person according to this policy and local endorsed procedures • Provide immediate patient and/or staff management according to this policy, including use of the Open Disclosure Standard where indicated • Assist with information gathering, investigation and analysis as requested • Implement required corrective actions

KEY TERMS

Actual (see Adverse Event)

Adverse event
An incident in which unintended harm resulted to a person receiving health care
An incident in which harm is caused to the organisation
In the context of this policy, *adverse event* means where minimal harm has been caused

Close call (see **Near Miss)**

Corrective Action
Corrective/remedial changes required to improve the system to address the root cause/s of the event. Actions can be strong, intermediate or weak. Examples of strong actions include architectural/physical plant changes; standardisation of equipment and processes. Intermediate actions include checklists and eliminating look and sound alikes. Weak actions include warnings and labels, new policies, procedures or directives and staff training.

Error
The failure to complete an action as intended, or the wrong use of or the wrong plan to achieve an aim. Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission)

Event
An incident or situation, which occurs in a particular place during a particular interval or time

Expression of regret
An expression of regret made by an individual in relation to an incident alleged to give rise to an action for damages for personal injury is any oral or written statement expressing regret for the incident to the extent that it does not contain an admission of liability (i.e. an admission of fault or

negligence) on the part of the individual or someone else. (s69 & 71 *Civil Liability Act 2003)*
An expression of regret made by an individual in relation to an incident alleged to give rise to an action for damages for personal injury at any time before a civil proceeding is started in a court in relation to the incident is not admissable in the court proceeding (s72 *Civil Liability Act 2003*)

Governance
The manner in which Queensland Health is directed, controlled and accountable for the achievement of its strategic goals and operational objectives. This includes a framework, structures and processes.

Harm
Death, disease, injury and or disability experienced by a person
Destruction, damage or threat to the organisation, loss of or damage to property, or pollution of the environment.

Incident
An event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage.

Incident monitoring
A system for identifying, processing, analysing and reporting incidents with a view to preventing their recurrence.

Intentionally unsafe acts
A criminal act; a purposefully unsafe act; an act related to alcohol or substance abuse by an impaired provider and/or staff; or events involving alleged or suspected patient abuse of any kind.

Liability
Responsible for an action in a legal sense.

Near hit (see **Near Miss)**

Near miss
An incident or close call that did not lead to harm, but could have.

Open Disclosure[5]
The process of open discussion of adverse incidents that resulted in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement.

Potential – A potential incident is a hazardous situation that is detected prior to the patient, customer, client, consumer or staff being harmed. This could include near misses. (see **Near Miss**)

Qualified privilege
Section 31 Health Services Act 1991 affords protection to members appointed to a committee which has been declared as an approved quality assurance committee under the Act. This means that the information which may be relevant to litigation and which there would normally be an obligation to provide, can be withheld from discovery in legal proceedings and is inadmissible as evidence in court proceedings.

[5] *Open Disclosure Standard* Australian Council for Safety and Quality in Health Care July 2003

	Risk Management The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects in order to improve the health and wellbeing of Queenslanders **Root cause** The most fundamental reason an event has occurred **Root cause analysis** A systematic process whereby the underlying factors which contributed to a sentinel event are identified **Safety** A state in which risk has been reduced to an acceptable level **Serious Adverse Event** An incident in which serious harm resulted to a person receiving health care and where the combined likelihood and consequence score (according to the Queensland Health Risk Matrix) is very high or extreme An incident in which serious harm resulted to the organisation and where the combined likelihood and consequence score is very high or extreme **Sentinel Event** An undesired event that signals that something serious or sentinel has occurred and warrants in-depth investigation (see Queensland Health list p.5) **Systems improvement** The changes made to dysfunctional operational methods, processes and infrastructure to ensure improved quality and safety **System failure** A fault, breakdown or dysfunction within an organisation's operational methods, processes or infrastructure

APPENDIX 1: QUEENSLAND HEALTH RISK MATRIX AND EXAMPLES OF CONSEQUENCES

The risk matrix combines consequences and probability resulting in a level of risk.

Incidents are classified according to POTENTIAL (near misses – therefore the probability rating or likelihood of occurring again is important to assess) and ACTUAL (the incident has occurred, so the consequences in terms of severity must be assessed first, then the probability of recurring).

	Consequences				
Probability (likelihood)	*Negligible*	*Minor*	*Moderate*	*Major*	*Extreme*
Rare	Low	Low	Low	Medium	High
Unlikely	Low	Medium	Medium	High	Very High
Possible	Low	Medium	High	Very High	Very High
Likely	Medium	High	Very High	Very High	Extreme
Almost certain	Medium	Very High	Very High	Extreme	Extreme

LEGEND

Low risk	Manage by routine procedures, unlikely to need specific application of resources
Medium risk	Manage by specific monitoring or response procedures
High risk	Senior executive management attention needed and management responsibility specified
Very high risk	Detailed research and management planning required at a senior level
Extreme risk	Immediate action required, senior management will be involved, preparation of detailed plan

ACTIONS:

- All high, very high and extreme risks are considered notifiable and must be reported to your line manager immediately.
- All notifiable events (including sentinel events) must be reported as directed.
- All incidents including near misses must be reported and recorded
- The risk assessment process is applicable to all processes and levels within the organisation.

Examples of Consequences by Degree of Severity – note Incidents in the Moderate to Extreme range are the focus of the Incident Management Policy

Consequence Table		Degree of Severity				
Type of Consequences		**NEGLIGIBLE**	**MINOR**	**MODERATE**	**MAJOR**	**EXTREME**
Adverse Clinical Incident	C	No injury or harm caused, minor adjustment to operational routine	Minimal harm caused, minor interruption to routine	Loss of function, major harm caused	Loss of life	Multiple deaths
Outrage/Damage to Reputation (local state or national media exposure or public outrage)	O	Minimal adverse local publicity	Significant adverse local publicity	Significant adverse statewide publicity	Significant and sustained statewide adverse publicity	Sustained national adverse publicity, Queensland Health's reputation significantly damaged
Litigation	L	Potential exposure to Queensland Health	Minor exposure to Queensland Health	Exposure will result in a single claim	Claims greater than $500,000 or multiple claims resulting from single exposure	Claims greater than $1M or multiple claims resulting from multiple similar exposures

Consequence Table		Degree of Severity				
Type of Consequences		NEGLIGIBLE	MINOR	MODERATE	MAJOR	EXTREME
Disruption to established routines/ operational delivery (may include industrial action, power failure, natural or man-made disaster etc)	D	No interruption to service	Some disruption manageable by altered operational routine	Disruption to a number of areas within a location or district, possible flow on to other locations	All operational areas of a location or district compromised, other locations or districts are affected	Total system dysfunction and/or total shut-down of operations
Staff Morale (may include absenteeism, establishment)	SM	Staff dissatisfaction within local unit. No effect on services or programs	Alteration to routine practice required in local area or district	Disruption spreads across services or programs	Disruption spreads to routine practice statewide	Statewide cessation of service or programs
Workplace Health & Safety (staff and other persons)	H	No injury / illness - no time lost, minor adjustment to operational routine	Injury / illness – lost time of less than 4 days	Serious injury / illness eg more than 4 days lost, or an event which is notifiable	Fatality	Multiple fatalities
Security (may include major fraud, theft, Information Security, terrorism security breach)	S	Event noted by local staff to management, no changes to routine required	Monitored by local staff, some effect on routine operations	Reportable event, some threat to program / service that requires investigation and review	Major event, threatens program / service across the wider organisation	Extreme event affecting organisation's ability to continue program / service
Environmental Impact (natural)	E	No lasting detrimental effect on the environment	Local detrimental effect on the environment	Short term local detrimental effect	Long term detrimental effect (eg significant discharge of pollutant)	Extensive detrimental long term effect (eg extensive discharge of persistent hazardous pollutant)
Workforce Issues (may include recruitment and retention, capability)	W	No effect on services or programs	Some effect on specific service or program – alterations to routine practice required	Restrictions to service or program availability within a location or district, with possible flow on to other locations	Cessation of service or program of a location or district, which could impact other locations or districts	Statewide cessation of a program or multiple programs
Operational Management	OM	No impact on local operations	Minor impact on local operations	Moderate to long-term impact on wider operations	Major impact on operations across other areas of organisation	Cessation of some operations
Corporate Management	M	Local management review	Management review on broader basis	Local executive management review	Zonal / Branch / whole services management review	Statewide management review
Financial (anything that has the potential to cost the organisation as a whole or any unit thereof money)	F	~ 1% of monthly / cost centre budget	~ 2% of monthly / cost centre budget	~ 5% of monthly / cost centre budget	~ 10% of monthly / cost centre budget	~ 15% of monthly / cost centre budget

Explanation of the degree of severity of Consequences

Negligible	The consequences are dealt with by routine operations. A budget overrun up to 1% of monthly / project budget would be of negligible consequence.
Minor	The consequences would threaten the efficiency or effectiveness of some aspects of the program but would be dealt with internally. A budget overrun up to 2% of monthly / project budget would be of low consequence.
Moderate	The consequences would not threaten the program, but would mean that the administration of the program could be subject to significant review or changed ways of operating. Budget overrun up to 5% of monthly / project budget would have moderate consequences for the organisation both financially and politically.
Major	The consequence would threaten the survival or continued effective function of the program, or require the intervention of top level management or by the elected representative/s Budget overrun up to 10% of total monthly / project budget would have very high consequences for the organisation both financially and politically.
Extreme	The consequences would threaten the survival of not only the program, but also the organisation, possibly causing major problems for clients, the administration of the program or for a large part of the public sector Budget overrun up to 15% of monthly / project budget would have extreme consequences for the organisation both financially and politically.

APPENDIX 2: SENTINEL EVENT NOTIFICATION REPORT TEMPLATE

Queensland Government
Queensland Health

URGENT MEMORANDUM

To: Director-General ATTENTION: Secretariat, Risk Management Advisory Group

Copies to: Click, enter CC's Name/s, Title/s

From: Click, enter Sender's Name and Title **Contact No:** Click, enter Sender's Tel No.

Fax No: Click, enter Sender's Tel No.

Subject: SENTINEL EVENT NOTIFICATION REPORT

File Ref: Click, enter Ref No.

I wish to advise that the following sentinel event has occurred in Click, enter location at Click, enter time and date:

TICK	LIST OF NOTIFIABLE SENTINEL EVENTS
	Surgery/procedure on the wrong patient/wrong body part
	Haemolytic blood transfusion reaction resulting from ABO incompatibility
	Instrument or other materials inadvertently left in body cavity or operation wound following a procedure
	Intravascular gas embolism resulting in death or neurological damage
	Infant discharged to wrong family
	Death of an employee during the course of their duties
	Suicide of a patient
	Death of a patient as a direct and immediate result of medication error
	Death of a patient during inter-hospital transfer
	Direct maternal death
	Sudden and unexpected death of an infant associated with labour or delivery
	Unexpected death of a patient during surgery
	Unexpected death of a patient
Mental Health specific	
	The suicide or unexpected death in respect of any patient (inpatient or community) of a mental health service, any person who has been in contact with a mental health service or emergency department within seven (7) days preceding the incident
	Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness
	Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness

Sponsor: Deputy Director-General, Policy and Outcomes
Issued by: Health Strategy and Funding Branch
Incident Management Policy
10 Jun 2004

In compliance with Queensland Health's Incident Management Policy, I advise that due procedures are underway and an investigation using the root cause analysis tool will commence on Click, enter date (should be 7 days from event occurring)

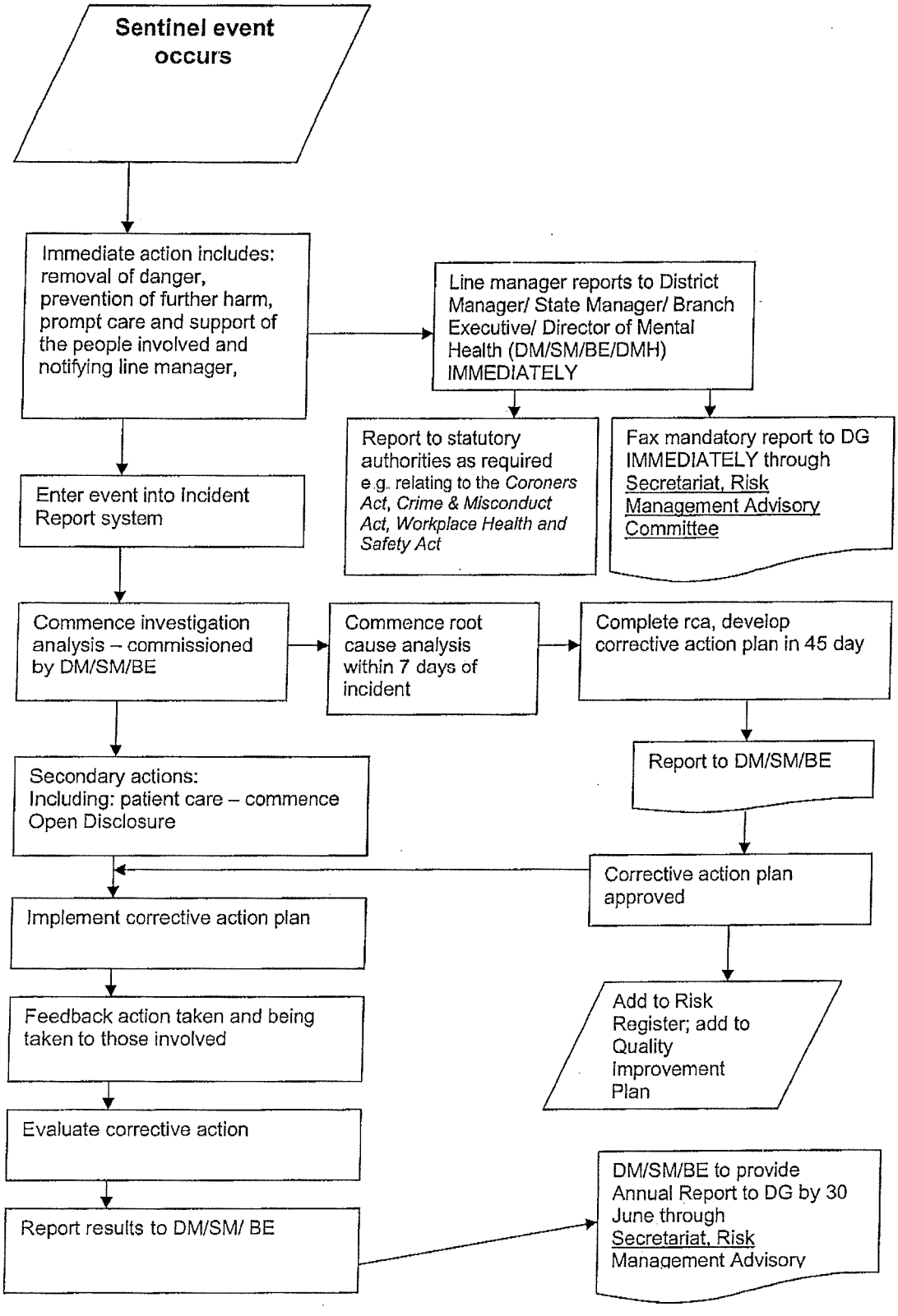
<< to be signed>>

Click, enter name
Click, enter title
/ /

TO BE SIGNED AND FAXED IMMEDIATELY

FAX TO: 07 323 71691

APPENDIX 3: FLOW CHART OF SENTINEL EVENT INCIDENT MANAGEMENT PROCESS (high level)



Sponsor: Deputy Director-General, Policy and Outcomes
Issued by: Health Strategy and Funding Branch
Incident Management Policy
10 Jun 2004

'JGW-7'

Queensland Sentinel Event Review April 2005

Purpose

Review the status of Sentinel Event reporting in Queensland and provide recommendations for improvement.

Background

In early 2004 Health Ministers committed to national targets for patient safety in relation to incident management. The targets pertinent to incident management were as follows:

- Public hospitals will introduce new 'incident management' systems to monitor, investigate, analyse and guide their actions in dealing with patient safety and quality incidents.
- All public hospitals will have in place a Patient Safety Risk Management Plan.
- All public hospitals are to report all Sentinel Events, and to contribute to a National Report on Sentinel Events.

Queensland Health introduced an Incident Management policy in July 2004. Integral to the policy is the mandatory reporting of an agreed list of Sentinel Events. It is worthwhile noting the policy required local areas to not only report but to conduct some form of analysis of the reported incident. The benefit of this was to facilitate the identification and implementation of recommendations for remedial actions.

Whilst the introduction of the policy has raised the awareness of Sentinel Event reporting, it is difficult to ascertain the effect the policy has had on the type, frequency and quality of analyses undertaken. The capacity to learn from Sentinel Events will be enhanced with the establishment of the Patient Safety Centre, with state-wide Root Cause Analysis training, specific reporting criteria, standardised reporting templates, and district Patient Safety Officers.

What do we want from Sentinel Event reporting?

Sentinel Event management will assist in reducing unintended patient harm by:

1. Local level identification of system deficiencies and development and monitoring of system improvements using human factors.
2. State-wide analysis of Sentinel Events with development and implementation of state-wide patient safety system improvements based on this information.

Current Queensland Health Sentinel Event reporting status

Since July 1st 2004 Queensland Health Services Districts have notified the Director General of some 84Sentinel Events. This compares favourably with the reporting rates of both NSW and Victoria who recorded some 31 and 79 Sentinel Events respectively in the first year of their programs (NSW Health: Patient Safety Clinical Quality Program

and Sentinel Event Program Annual report 2003-04: State government of Victoria). Thus far NSW and Victoria are the only states to have published data on Sentinel Events.

The table below illustrates the number of Sentinel Events reported by Queensland Health Services Districts for the period July 1 2004 to April 30 2005.

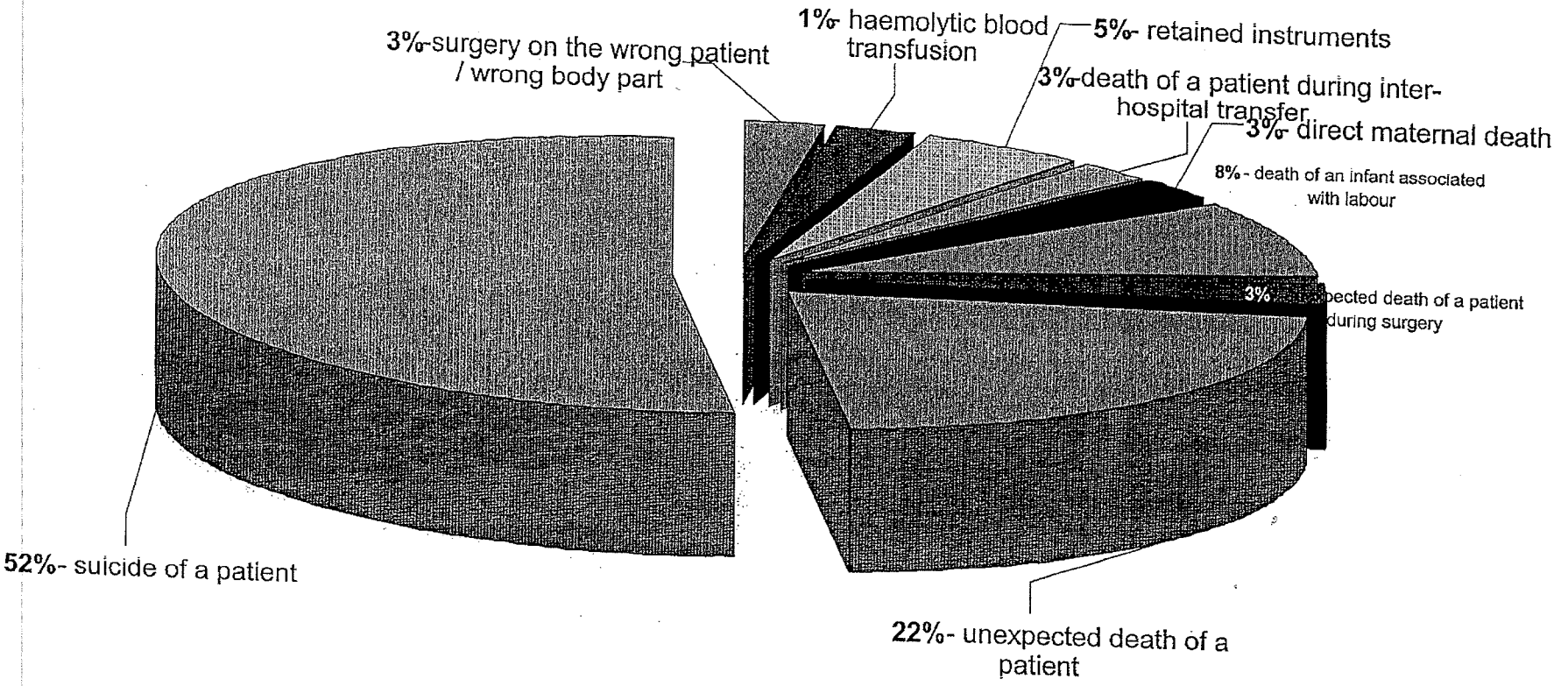
QLD Sentinel events July 2004- April 2005

LIST OF NOTIFIABLE SENTINEL EVENTS	Number
Surgery/procedure on the wrong patient/wrong body part	2
Haemolytic blood transfusion reaction resulting from ABO incompatibility	2
Instrument or other materials inadvertently left in body cavity or operation wound following a procedure	4
Intravascular gas embolism resulting in death or neurological damage	
Infant discharged to wrong family	
Death of an employee during the course of their duties	
Suicide of a patient	
Death of a patient as a direct and immediate result of medication error	
Death of a patient during inter-hospital transfer	2
Direct maternal death	2
Sudden and unexpected death of an infant associated with labour or delivery	9
Unexpected death of a patient during surgery	2
Unexpected death of a patient	19
Subtotal	42
MENTAL HEALTH SPECIFIC	
The suicide or unexpected death in respect of any patient (inpatient or community) of a mental health service, any person who has been in contact with a mental health service or emergency department within seven (7) days preceding the incident	42
Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness	
Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness	
Subtotal	42
Grand total	84

Compliance with reporting has been improving with most districts reporting at least one Sentinel Event in the 10 months since implementation of the policy. The main method of communication has been by fax although some districts are beginning to report through PRIME. PRIME will generate a Sentinel Event memo once the relevant data has been entered into the system.

Figure 2

The graph below shows the categories of reported Sentinel Events by percentage of the total number reported for the period July 1 2004 to current



Note: Not all Districts have submitted final analyses for their individual Sentinel Events. The current rate of final reports to Sentinel Event notifications is 32%.

Contribution to Queensland health to National Sentinel Event Report

Queensland Health will be asked to contribute to a National report on Sentinel Event in the near future. Currently the Queensland Health Sentinel Event list differs substantially from that used by NSW and Victoria both of whom have released data on Sentinel Events. Any attempt to contribute on the basis of our current list will make comparison and analysis of data difficult. (See below).

Table 2. National Sentinel Events

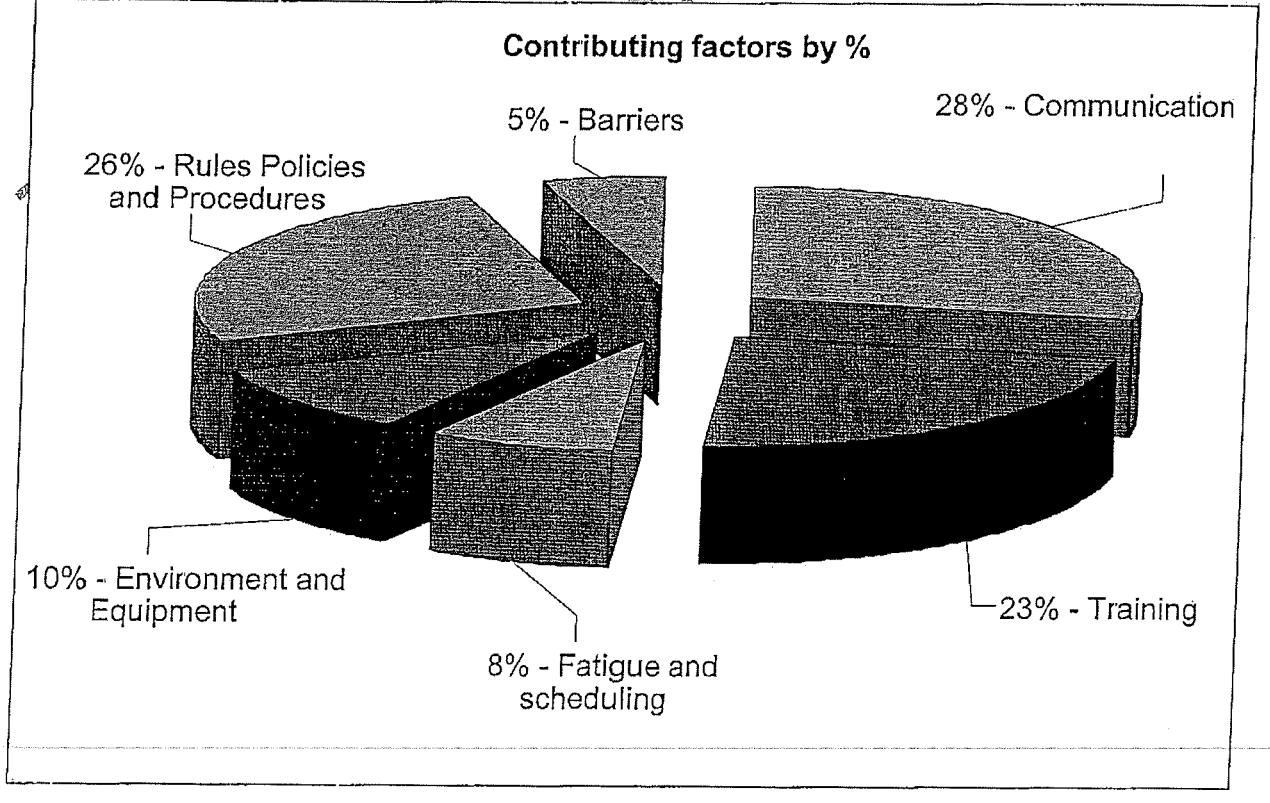
Sentinel Event	NSW (2003/04)	Vic 2003/04	Qld 2004/05	
Procedure involving the wrong body part	13	14	2	
Suicide in hospital	4	1	(refer below)	
Retained Instrument or other material after surgery requiring further special procedure	9	8	4	
Medication error resulting in death of a patient	2	4	0	
Intravascular gas embolism resulting in death or neurological damage	0	0	0	
Haemolytic blood transfusion reaction resulting from ABO incompatibility	0	1	2	
Maternal death or serious morbidity associated with labour	3	2	9	
Infant discharged to wrong family	0	0	0	
Unexpected death of a patient during surgery			2	*Queensland Health Specific*
Unexpected death of a patient			19	
Death of a patient during inter-hospital transfer			2	
Direct maternal death			2	
The suicide or unexpected death in respect of any patient (inpatient or community) of a mental health service, any person who has been in contact with a mental health service or emergency department within seven (7) days preceding the incident			42	
Total	31	30	84	

As the above table indicates many of the classifications currently adopted by Queensland Health are expressed differently to those used and reported on by NSW and Victoria. It is important to note that the Mental Health specific category currently on the Queensland Health Sentinel Event list encompasses unexpected deaths and suicides of Mental Health patients as inpatients and those who may or may not be under case management by community care services or who have been seen within the previous seven days prior to death.

This means that districts are reporting all community suicides / unexpected deaths as Sentinel Events and convening Root Cause Analysis (RCA) teams in accordance with the Incident Management Policy. Of the 42 reported incidents relating to Mental Health suicides and deaths only 3 have occurred within a Mental Health unit or health care facility i.e.: *found deceased in a hospital.* The remaining 39 have related to community outpatient deaths or inpatient absconds that resulted in suicide. The higher numbers of reported Mental Health suicides and therefore total number of Sentinel Events by Queensland Health facilities when compared to NSW and VIC relates in part to the descriptor and interpretation there-of on the Qld Sentinel Event list

RCA final reports and contributing factors

To date there have been 84 Sentinel Events reported and some 26 final analyses submitted to the Patient Safety Centre by Health Services Districts. A memorandum has been sent to all districts who have submitted Sentinel Event notifications to communicate the outcomes of incident analyses. As this information comes to light further analysis of the data will be possible. A preliminary review of the contributing factors associated with each Sentinel Event reveals the following percentage breakdowns by classification utilising the Veterans Health Administration classification system outlined in the National Centre for Patient Safety (NCPS) triage cards.



It is difficult to fully analyse the data to date primarily due to the small number of reports received. Furthermore the quality of the reports varies significantly from district to district, as there is no standard presentation template for Sentinel Events and only two of the districts have RCA trained Patient Safety Officers. In relation to the current data available 42 of the 84, (approximately 50%) of Sentinel Event notifications relate to Mental Health deaths.

Recommendations

A number of issues are currently being addressed by the Patient Safety Centre, to improve the rate of Sentinel Event reporting and incident final analysis report submission. These are as follows:

Sentinel event list

Reviewed to:

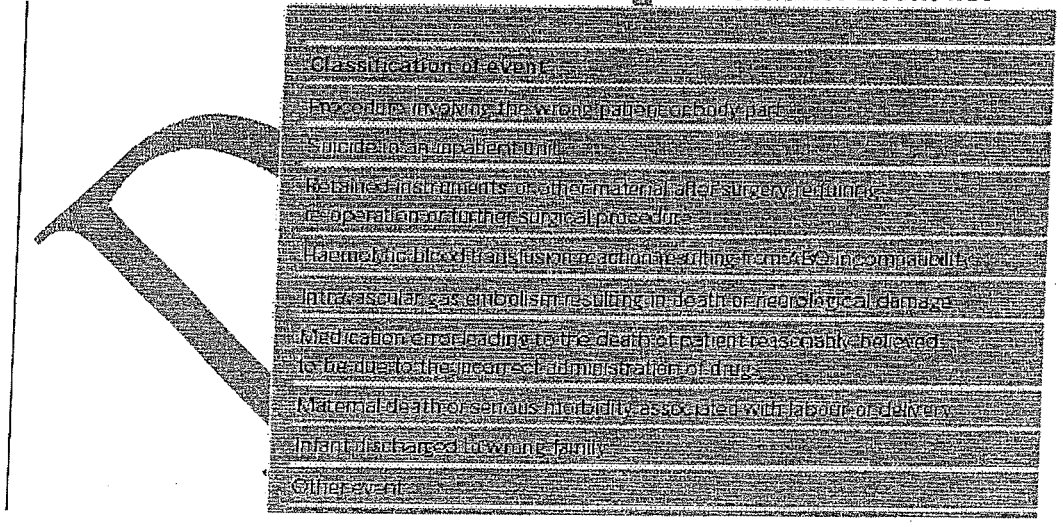
1. Reduce the current Queensland Health Sentinel Event list to the basic 8 as published by the Australian Council for Quality and Safety and utilised by NSW and Victorian Health Services (see below).

   This will:

   a. Align Qld with already published data by other states.
   b. Validate a nationally recognised Sentinel Event list.
   c. Facilitate more accurate data and knowledge sharing across the states and promote accurate national learning.

Example 1

State Government of Victoria - Sentinel Event list



2. Mental Health Sentinel Events definitions require further clarification.

    a. NSW and Victoria use "Suicide in hospital" and "Suicide in an inpatient unit" respectively. Mental Health need to clarify what "Suicide in an inpatient unit" would mean for their specialty and whether it captures the required information.

3. Further definitions of "other event" and "near miss" should be developed. Consideration should be given to the inclusion of *"Other reportable event"* or *"Other notifiable event"* as a ninth Sentinel Event category.

    a. What are the implications for Mental Health and what are their requirements to ensure that significant unexpected deaths and / or suicides, other than in-patient suicides are notified as Sentinel Events.

    b. If unexpected deaths and suicides other than for inpatients are deemed reportable i.e.: Community suicides, what is the level of discretion for District Mental Health Units for reporting and subsequent analysis of these incidents.

    c. Consultation with other specialty areas may be required to ascertain what types of incidents would meet an *"Other reportable event"* or *"Other notifiable event"* criteria. Clarify "other reportable" critical incidents or secondary categories – If Queensland Health uses the national list, this subset of incidents will definitely be the cluster to learn from. As the category is far more common, Human Error and Patient Safety (HEAPS) analysis may be all that can be achieved with occasional RCA's specified. How will districts get through the work – and implement the large number of changes and recommendations?

4. Mental Health Services need to clarify what "other events" are notifiable or require an RCA in accordance with the Incident Management policy.

5. Facilitate the sharing of solutions through the development of an ***"Alerts and Advisories"*** system developed in part form reported and analysed Sentinel Events.

6. The same Sentinel Event list should be used for concurrent years to allow for state comparisons.

Incident management policy

Reviewed for:

1. Specificity for reporting. I.e.: The policy needs to be very clear about communication of outcomes from District RCA final reports to the Patient Safety Centre and how this information will be released or published
2. The Sentinel Event list itemised within the Incident Management Policy must reflect
    a. Memo on website
    b. Memo within PRIME

Current Action Plan

1. To define a process / pathway for maintenance of sentinel events at the Patient Safety Centre.

2. To contact all District Managers who have previously reported Sentinel Events to encourage completion of final analysis and communication of relevant findings to the Patient Safety Centre.

3. To review links to Mental Health - Corporate Office - the majority of reported Sentinel Events have been Mental Health suicides and deaths of varying type. There are currently two reporting pathways that do not necessarily link and discrepancies exist between reported and actual Mental Health deaths. This is less of an issue than was first thought however some centres believe that they have reported if they have notified Mental Health - Corporate Office and have not seen the need for further reporting to the Patient Safety Centre.

4. To develop a State Sentinel event reference number that is allocated at the time of reported – this could potentially be generated through PRIME.

5. To provide feedback to each district upon receipt of Sentinel Event notification and final report – single point reference essential.

6. To provide regular contact with district Patient Safety Officer from the Patient Safety Centre particularly during the RCA phase to provide support and guidance.

7. To Analyse the completed reports for contributing factors and trends

Outcomes

Issues	Completed
An electronic data base for reported Sentinel Events has been established	Yes
Hard copies of all Sentinel Events and corresponding final RCA reports are numbered and filed in relevant folders.	Yes
A standard pathway for collecting, filing and data entry has been established	Yes
E-mail feedback to individual districts as Sentinel Event notifications are received has been established.	Yes
A Sentinel Event numbering system has been established for the Patient Safety Centre. This has been communicated to districts that have already reported Sentinel Events and will be further promulgated as new districts report.	Yes
A memorandum from the Patient Safety Centre in regards to the submission of final RCA reports has been sent to all District and Zonal managers who have previously submitted Sentinel Event notifications.	Yes

Issues continued	Completed
A review of the Sentinel Event list has been specifically requested within the Incident Management policy review currently in progress. *Specific comment on the useability and specificity of the existing Sentinel Event list has been requested from districts.*	**Yes**
Consultation with NSW Health regarding the progress, development and lessons learned form their NSW Sentinel Event program is underway.	**Yes**
Consultation with Mental Health Corporate office in relation to the definition of Mental Health specific Sentinel Events has commenced. Specific advice on the classification of "Suicide in an inpatient unit" or "Suicide in hospital" as used by NSW and Victoria respectively has been requested	**Yes**

It is anticipated that the any changes made to the Sentinel Event list and reporting in general will need to be completed and incorporated into the training packages for the proposed roll out of Patient Safety Officers scheduled for July 2005.

Hayden Scotter

A/ Principal Project Officer
District Engagement
Safety Improvement Unit
Patient Safety Centre
Skills Development Centre
RBWH
Herston

References:

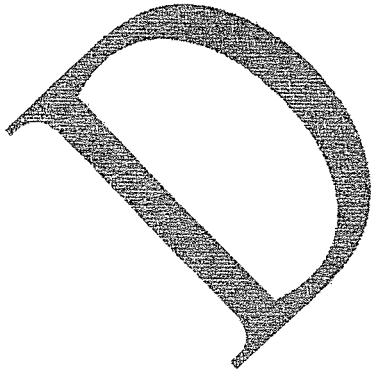
1. Queensland Health Incident Management Policy – Health Strategy and Funding Branch, 10 July 2004

2. Patient Safety and Clinical Quality Program. First report on incident management in the NSW public health system 2003 – 2004

3. Sentinel Event program – Annual report 2003-2004. State government of Victoria.

4. Sentinel Event program – Annual report 2002-2003. State government of Victoria.

5. http.www. Safety and Quality.org – functnlspecs.doc.url



'JGW-8'

Queensland Government
Queensland Health

HEALTH SERVICE DISTRICT
JOB DESCRIPTION

POSITION NUMBER:	(Lattice Number)	
POSITION TITLE:	Patient Safety Officer	
DIVISION/BRANCH/SECTION:	Safety Quality Risk Management	
LOCATION:	(local Health Services District)	
CLASSIFICATION LEVEL:	A06	
SALARY LEVEL:		
REPORTS TO:	District Manager	
AWARD:	District Health Services Award	
DATE OF REVIEW:	July 2005	
DELEGATE'S AUTHORISATION:	**NAME:**	**DESIGNATION:**
	SIGNATURE:	**DATE:**

PURPOSE OF POSITION

To provide expertise and leadership to support the clinical incident management system and related patient safety activities.

ORGANISATIONAL ENVIRONMENT

Queensland Health is a dynamic organisation committed to providing a range of services aimed at achieving good health and well-being for all Queenslanders. Through a network of 38 Health Service Districts and the Mater Hospitals, Queensland Health delivers a range of integrated services including hospital inpatient, outpatient and emergency services, community and mental health services, aged care services and public health and health promotion programs. The attached Queensland Health organisational chart depicts the structure and integration of State Health services within Queensland.

(Insert local Health Service District statement if required)

REPORTING RELATIONSHIP

This position reports to the **District Manager or delegate** at the (insert Local Health Service District). This position also has an indirect reporting relationship to the Director, Safety Improvement Unit - Queensland Health Patient Safety Centre as outlined in the Service Level Agreement.

SUPERVISES

This position has no supervisory responsibilities

POSITION REQUIREMENTS

Queensland Health is committed to achieving our mission of promoting a healthier Queensland and our vision to be leaders in health – partners for life. We recognise that Queenslanders trust us to act in their interest at all times. To fulfil our mission and sustain this trust we share four core values of: quality and recognition; professionalism; teamwork; and performance accountability. In addition we will be successful in promoting a healthier Queensland through the following five strategic intents; healthier staff; healthier partnerships; healthier people and communities; healthier hospitals and healthier resources. The primary duties and assessment criteria outlined in this job description reflect the commitment to our mission, vision, values and strategic intents which are required by this position.

DUTIES AND RESPONSIBILITIES

Incident Analysis (such as Root Cause Analysis, Task Safety Analysis and Human Error and Patient Safety (HEAPS) review

1. To facilitate and provide technical expertise for the multi disciplinary review and analysis of very high and extreme risk clinical incidents and sentinel events using the Queensland Health Incident Management Matrix and Root Cause Analysis (RCA) methodology.

2. Communicate on patient safety issues and develop strategies to disseminate "lessons learned" from RCA and other incident analysis /reviews at a local level.

3. Communicate with the Queensland Health Patient Safety Centre regarding RCA outcomes, preventative measures and relevant implications for state-wide learning.

4. Coordinate Health Service District reporting of sentinel events as outlined in the Queensland Health Incident Management Policy No 23360.

5. Maintenance of the local Health Service District RCA action registers.

6. Facilitate regular reporting to Health Service District Executive groups and relevant Health Service District Safety and Quality forums on RCA progress and outcomes for patient safety activities.

7. Provide support for low, medium and high risk incident analysis.

8. Evaluate, conduct and support regular audits to identify patient safety issues and assist in monitoring interventions.

Technical Advice

1. Provide technical and expert advice to the Health Service District Executive, District Safety and Quality forums and individual clinical units in regard to patient safety and clinical risk management issues.

2. Liaise with non clinical risk management personnel for incident management with both a clinical and non-clinical component.

Projects

1. Lead or support the development and implementation of projects designed to deliver improved safety outcomes for patients.

Training

1. Consult with clinicians and management to identify patient safety training needs. Assist in the development and/or delivery of patient safety training to support the development of a safety culture.

General Duties

1. Promote patient safety at local, state and national level by communicating achievements and "lessons learned" in all relevant forums.

2. Maintain current knowledge in the specialist area including new developments, legislation and industry standards.

3. Assist all employees within the (insert local Health Service District) to achieve an organisational culture, in which patient safety and clinical risk management becomes an integral part of core business.

4. To act in accordance and ensure compliance with relevant Workplace Health and Safety, Equal Employment Opportunity and Anti-discrimination Acts, legislation and requirements.

5. Perform other duties, activities and deliverables as outlined in the Queensland Health Patient Safety Centre Service Level Agreement.

WORKPLACE BEHAVIOURS

Staff Management	Builds an environment that encourages loyalty and respect from staff and utilises strong communication skills to effectively manage staff according to relevant regulations and policies.
Customer Focus	Utilises strong questioning skills and a consultative approach to accurately interpret customers' needs and demonstrates strong problem solving skills to provide a flexible service that meets these needs.
Organisation and Planning	Have a vision for the local Health Service District patient safety objectives.
Continuous Improvement	Consistently demonstrates best practice and a commitment to quality standards, proactively identifying needs for improvement and showing initiative in meeting these improvement needs.
Continuous Learning	Maintain up-to-date knowledge and an active involvement in the profession, sharing information with others and promoting a learning environment through their actions.
Team Focus	Supports a team environment by showing respect, acknowledging and validating other team members.
Work Values	Demonstrates honesty, integrity and respect for all patients, carers and staff.

CLINICAL AND TECHNICAL EXPERTISE

- Demonstrated knowledge of the principles of patient safety and of Quality Improvement strategies related to incident prevention and monitoring systems.
- Knowledge of or ability to rapidly acquire knowledge of patient safety tools eg. Root Cause Analysis, Task Safety Analysis (TSA), HEAPS review and Healthcare Failure Mode and Effect Analysis (HFMEA).
- Proven ability to plan and develop tools, strategies, policies and procedures that support and facilitate a multidisciplinary team approach to patient safety activities.
- Proven high level of interpersonal and communication skills, both within and between health care disciplines, including the capacity to consult, negotiate and resolve conflict; to build and maintain productive working relationships and provide effective leadership.
- Demonstrated knowledge of the processes of project management, change management and quality improvement.
- Demonstrated strategic, analytical and conceptual skills and knowledge of processes and systems to monitor and improve organisational performance.
- Ability to produce documents of high quality. This will require proficiency with Microsoft Office suite, particularly Word, Excel and Powerpoint.
- Proven ability to coordinate and deliver training packages for healthcare professionals.
- Extensive clinical knowledge and/or experience.

ADDITIONAL FACTORS

Health Care Workers in Queensland Health whose occupation poses a potential risk of exposure to blood or body fluids must be immunised against Hepatitis B according to the National Health and Medical Research Council Australian Immunisation Handbook 7th edition and the Queensland Health Infection Control Guidelines. Hepatitis B immunisation is a condition of employment for Health Care Workers in Queensland Health, who have direct patient contact (eg medical officers, nurses and allied health staff), as well as those staff who, in the course of their work, may be exposed to blood or body fluids, for example by exposure to contaminated sharps e.g. (but not confined to) plumbers. Proof of vaccination must be provided to the Human Resource Management Department before/with acceptance of appointment. Proof of vaccination can be provided via a letter from a general practitioner, infection control or occupational health department.

PROBATION

All new **permanent** employees to Queensland Health will be required to undertake a period of probation upon commencement of duty. This period will be 3 months in length with a possible 3 months extension if performance objectives are not met.

PRE-EMPLOYMENT CHECKS

This position may be subject to pre-employment history checks including a working with children suitability check (Blue Card), criminal history, identity or previous discipline history checks for the preferred applicant.

ASSESSMENT CRITERIA

Applicants should submit a covering letter and resume and responses to selection criteria.

ASSESSMENT CRITERIA	WEIGHTING
SC 1 - Demonstrated understanding and ability to apply the principles of patient safety and human factors in a clinical setting.	**10**
SC 2 - Demonstrated ability to lead change, particularly in the context of multidisciplinary teams.	**10**
SC 3 - Demonstrated ability or ability to rapidly acquire technical knowledge and skills in patient safety tools including Root Cause Analysis (RCA).	**10**
SC 4 - Demonstrated high level verbal and written communication and interpersonal skills. Ability to provide training and education on safety issues to clinical and non-clinical staff.	**10**
SC 5 - Demonstrated ability to comply with legislation, Queensland Health standards, policies and agreements, support and facilitate action on corporate policies and programs and behave in accordance with the Queensland Health values and code of conduct.	**10**

Queensland Health Patient Safety Program -Develop a Culture of Patient Safety

1. Summary of Initiative

This initiative will provide a comprehensive Patient Safety System for Queensland Health. It will deliver a coordinated approach to the identification, prioritisation and treatment of system vulnerabilities that lead to patient harm. This will be achieved by building capacity at health service district level, supported and coordinated through a central unit.

2. A picture of what health services should look like in 5 years based on this initiative

- There will be a measurable improvement in the safety culture within Queensland Health
- A number of key statewide safety initiatives will have been implemented with demonstrable improvement in patient safety
- Standardised processes utilised in all districts for the identification, prioritisation and treatment of vulnerabilities that lead to patient harm

3. A brief synopsis of the proposal

The basis of the proposal is to:

- Build local and central capacity to identify vulnerabilities and to implement change based on system redesign utilising sound human factors principles
- Coordinate and facilitate change and work in true partnerships
- Recognise and build on work already undertaken
- Consolidate and coordinate existing programs with a patient safety focus, prioritising and focusing on a smaller number of deliverable patient safety projects across the state
- Ensure AHMAC targets are met.

The proposal is in 3 phases

Phase 1 is to:

- provide local resource in Health Service Districts (25 patient safety officers) and
- Establish a central program area to coordinate the initiative
- address urgent and immediate concerns regarding training and awareness of the Incident Management Policy and root cause analysis methodology
- develop and implement and clinical incident and complaints management information system.

Phase 2 is to establish a data management and analysis area to the new data bases of sentinel events, clinical incidents, complaints and coronial data.

Phase 3 is to consolidate and build further capacity by:

- Identify, develop and implement key safety initiatives for statewide implementation

- Establishing patient safety advice and directives for QH and the monitoring of these
- Further developing tools, training and education packages for patient safety

4. An Estimated Annual Cost

Costs	04/05	05/06	06/07	07/08	08/09
Labour	$2,065,847	$4,108,633	$4,108,633	$4,108,633	$4,108,633
Total	$3,000,913	$4,772,948	$4,695,948	$4,695,948	$4,695,948
Contingency 10%	$300,000	$477,295	$469,595	$469,595	$469,595
Grand total	**$3,300,913**	**$5,250,243**	**$5,165,543**	**$5,165,543**	**$5,165,543**

5. Industrial and special interest issues that may stop successful implementation

There are several issues that will need to be resolved as this program is developed and implemented. These form the basis of critical success issues and are as follows:

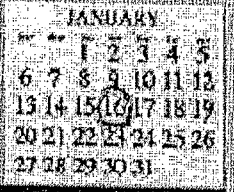
- The leadership and relationship between SED, I &WFR and the SED HS is critical to the success of this program.
- The coordination and integration of safety, quality and risk needs to be undertaken and what does this mean at the coal face.
- The patient safety program will incorporate targeted safety project interventions eg 'correct site surgery' and ongoing functional safety program areas eg 'medication safety'. How this is undertaken is critical.
- The over-arching governance arrangements and decision making will need to be clarified.

Additional issues for consideration:

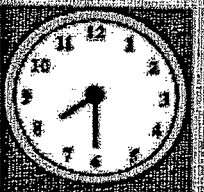
- Leadership needs to be resiliant especially in the face of possible initial adverse publicity – this would be addressed through an extensive communication strategy
- Clarification of issues surrounding privilege and indemnity

Ensuring Correct Patient, Correct Site, Intended Procedure

Days to hours before procedure



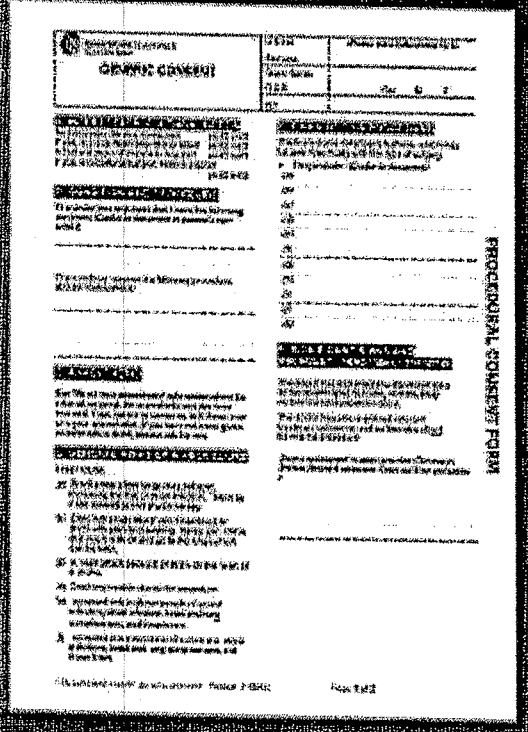
Just before entering operating theatre or treatment room



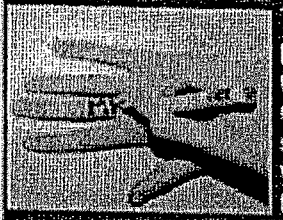
Immediately prior to procedure

Step 1: Informed Consent Check

The consent form must include:
- patient's full name
- procedure site with laterality
- name of procedure
- reason for procedure



Step 2: Mark the Site



The operative site for an invasive procedure must be marked (initials) by the person in charge of the procedure or another senior medical team member who has been fully briefed about the operation or procedure.

! Do NOT mark non-operative sites

Step 3: Identify Patient

On admission to Operating Suite

Staff must ask the patient to state (NOT confirm):
- their full name
- date of birth
- site for, or type of procedure

! Check responses against the marked site, ID band, consent form and other documents

Final Check

The surgeon must lead the Final Check and all non-critical work in the Operating Room must cease during the check. Ideally it is best to carry out this step when the patient is awake. However, if this is not possible then the step can be performed post induction of anaesthesia but pre- prepping and draping. Team members must verbally confirm through a team check:
- Correct patient (name, date of birth or UR number)
- Correct surgical procedure
- Correct marking of surgical site(s)
- Prosthesis available if required
- Imaging data correct and properly labelled

RACS ANZCA RANZCO AOA

PNAQ S&Q Council Queensland Government QHealth

Patient Safety Centre
Ensuring Intended Surgery Policy 26961

This Protocol has been adapted with kind permission from the Department of Veterans Affairs National Center for Patient Safety (USA) Directive on Ensuring Correct Surgery.

IGW-9

Queensland Government
Queensland Health

Policy Identifier: 26961

QUEENSLAND HEALTH POLICY STATEMENT

Policy Title	Ensuring Intended Surgery
Policy Statement	**Purpose:** The Ensuring Intended Surgery policy provides specific information on what steps must be taken to ensure that the indicated surgical procedure(s) is performed on the correct patient, at the correct site, and if applicable with the intended implant. ***NOTE:*** *Correct site includes the correct side (i.e., left or right) and the correct precise anatomical location, e g., specific vertebral body or finger* All Queensland Health facilities, where surgery is performed, must implement the following 4 STEP process (Attachments 1 & 2) in order to reduce the likelihood of incorrect surgery. Attachment 1 = Written description of protocol on page 3 Attachment 2 = Poster on page 7
Principles	The sentinel events of wrong-site surgery, wrong surgery, and surgery on a wrong patient, are preventable. It is the aim of Queensland Health to ensure a uniform protocol in all Queensland Health hospitals so as to minimise the occurrence of such events.
Scope and Application	All Queensland Health employees (permanent, temporary, and casual) and all organisations and individuals acting as its agent including Visiting Medical Officers.
Effective date	2005
Supersedes	New Policy
Compliance	Compliance with this policy is mandatory.
Further information	Executive Director of the Patient Safety Centre is responsible for reviewing this document at intervals of not greater than 1 year

Queensland Government
Queensland Health

QUEENSLAND HEALTH INSTRUCTION
to Policy Statement No. 26961

Policy Title	**Ensuring Intended Surgery**
Effective Date	17th March 2005
Review Cycle and Responsibilities	Safety Improvement Unit, Patient Safety Centre, will review this policy at least every twelve months. This review will be undertaken in conjunction with perioperative services' staff. Key performance indicators (KPI), congruent with the principles in the policy, will be established and the checking process evaluated against them in order to check if there is a decrease in the variance of the checking process.
Legislation and Associated Documentation	• Royal Australasian College of Surgeons Correct Side and Correct Site Surgery Guidelines, November, 2004. • Australian Council for Safety and Quality in Health Care. Visited 08/04/04. Available at: www.safetyandquality.org/ • Department of Veterans Affairs National Centre for Patient Safety: Ensuring Correct Surgery. Visited 06/04/04 Available at: www.patientsafety.gov/CorrectSurgDir.pdf • Queensland Health Informed Consent for Invasive Procedures (14025) • Guardianship and Administration Act 2000. • Queensland Health Integrated Risk Management Policy (13355) • Queensland Health Incident Management Policy (23360) • Queensland Health Code of Conduct (2000) • Indemnity for Queensland Health employees and other approved Medical Practitioners IRM 3.8-3 & 3.8-4, December, 2002 http://www.health.qld.gov.au/industrial_relations/Masters/SECT3/irm3_8_4.pdf & http://www.health.qld.gov.au/industrial_relations/Masters/SECT3/irm3_8_3.pdf
Corporate Office file	1236-0355-114 G:\Patient Safety Centre\Project officers\Patient Safety\correct surgery\policy\Ensuring Intended Surgery Policy H.DOC

CONTENTS

EVIDENCE SUPPORTING THE POLICY

Evidence of the incidence of wrong site surgery

Wrong-site surgery is devastating and yet it is a completely preventable sentinel event (DiGiovanni, Kang, & Manuel, 2003) Statistics taken from overseas and Australia indicate similar results. In the year 2001, the Veterans Health Administration reported 1 wrong-site surgery in 30,000 surgical procedures, which equates to approximately 1 per month (Department of Veteran Affairs, 2004). Likewise, in one Australian state, there were 16 procedures involving the wrong patient or body part over the year 1st July 2002 to 30 June 2003, which calculates to approximately 1.3 per month (Department of Human Services, 2004).

Evidence to support the system solution

Analysis of multiple Root Cause Analyses from the Veterans Health Administration (2004) led to the identification of 5 specific vulnerabilities which led to wrong surgery. A process was developed and piloted that addressed these common system failures. These were:

Step 1 Including the site of the procedure, name of the procedure and the reason for the procedure in **Step 1: Informed Consent Check** (this would have prevented 45% of the number of wrong-site surgery incidents)

Step 2. Having the surgeon and patient collaboratively carry out **Step 2: Mark the Site**, (this would have prevented 65% of wrong site incidents)

Step 3. Asking the patient to state his/her details instead of confirming at **Step 3: Identify Patient** on admission to Operating Suite (this would have prevented 75% of wrong site incidents)

Step 4. Taking time out in the Operating Room to do **Step 4: Final Check**, when members of the team check the patient's details and type of surgery (this would have prevented 85% of wrong site incidents) and having two members of the team check images for surgery (this would have prevented 20% of wrong site incidents).

COMPLIANCE AND RESPONSIBILITIES

Role/Function	Responsibilities and Specific Accountabilities
Director-General	Ultimately accountable/responsible for the operation of the Department, including the implementation of the Ensuring Intended Surgery protocol The Director-General is supported by the roles/positions below in implementing, evaluating, and reviewing the protocol.
SED Health Services Zonal Managers	Responsible for facilitating implementation at Queensland Health facilities. Ensuring that this protocol is coupled with their overt support. SED = Senior Executive Director
SED IWR ED Patient Safety	Responsible for developing, reviewing, and evaluating the policy, as well as providing education, support for implementation, and compliance review. IWR = Innovation and Workforce Reform Directorate ED = Executive Director
District Managers EDMS EDNS	Responsible for facilitating implementation at the local level of Queensland Health facilities and overtly demonstrating their support for the protocol. EDMS = Executive Director Medical Services EDNS = Executive Director Nursing Services
Treating Medical Officers	Responsible for compliance with Ensuring Intended Surgery protocol.

IMPLEMENTATION PROCESS

Ensuring Intended Surgery requires a 4 STEP process (see poster). The steps are:

Step 1. Informed Consent Check
Step 2. Mark the Site
Step 3. Identify Patient on admission to Operating Suite
Step 4. Final Check

Step 1. **"Informed Consent"** Treating Medical Officers (TMO) are responsible for this step and their responsibilities are clearly stated in the Informed Consent for Invasive Procedures Policy No. 14025 (http://www.health.qld.gov.au/informedconsent). Responsibilities include:-

- Providing the patient or the patient's substitute decision maker about the necessary information so that the patient is adequately informed about his/her surgery.
- Clearly stating on the Informed Consent the patient's full name, surgery to be performed, site and side of surgery. The side of the operation must be written in full, for example LEFT must not be abbreviated to "L."
- Letting the patient know that the checking process for the Operating Rooms involves marking on his/her operative body part with the surgeon's initials.
- Obtaining consent from the patient or the patient's substitute decision maker in accordance with the principles set out in the Informed Consent for Invasive Procedures Policy.

Rationale: *This is to ensure that the patient understands* ***where*** *the surgeon intends to operate, as well as* ***what*** *procedure is to be performed and* ***why****. To improve safety, it gives the patient or their representative the opportunity to identify a mistake at a time that is removed from when the surgery is imminent when there may be many distractions that prevent attention to what is on the consent form.*

*NOTE: In order to consent, the patient must possess a **decision-making capacity**, be **fully informed**, and **participate voluntarily** Decision-making capacity is defined in the Guardianship and Administration Act 2000 as "the ability to understand the nature and effect of the decision; decide freely and voluntarily; and communicate the decision in some way." Decision-making capacity may be precluded by a disease state or heavy sedation. It needs to be noted that sedation by itself does not prevent the patient from possessing a decision-making capacity; the patient's decision-making capacity must be determined based on the facts of the particular circumstance. For example, a patient who is extremely anxious may actually be better able to provide informed consent once an anxiolytic drug is given. Similarly, a patient in pain should not be denied the necessary pain medications.*

Step 2. **"Mark the Site"** The TMO who is performing the surgery or another medical officer who is a member of the surgical team assigned to be present in the Operating Room during the procedure is responsible for this step. It is highly preferable to carry out marking prior to the patient entering the Operating Room and before induction of anaesthesia. Therefore marking should be attended to before Step 3 "Identify Patient on admission to Operating Suite," but **must** be attended to before Step 4 "Final Check." Responsibilities include:-

- Consulting with the patient or the patient's substitute decision maker as well as verifying with the signed Consent Form, the correct site and side of surgery.
- **Signing unambiguously with his or her initials within the operative field**. For example, it is not appropriate to mark the right hand when in fact the index finger of the right hand is being operated on. In cases involving multiple skin lesions, then the surgeon's initials will be written with a numeric superscript in chronological order of importance for surgery.
- Using the recommended tool for marking the operative site(s) that is an indelible Artline 750 pen
- Not marking non-operative sites.
- Halting the proposed surgery if there is a discrepancy in this part of the checking process until the discrepancy can be resolved to the satisfaction of the TMO and the patient.

If the anaesthetist is performing the first invasive procedure such as a local anaesthetic block, it is their responsibility to ensure that Step 2 has been done.

Exceptions

- In the case of upper and lower gastro-intestinal endoscopy procedures no marking is required.
- In the case of teeth extractions and other dental surgery no marking is required (a diagram is the ideal way of demonstrating the site and side of surgery in these cases).
- In the case of severe burns with multiple skin grafting, and some Ear Nose and Throat surgery, such as a tonsillectomy, no marking is required.
- In the case of a spinal surgery, the operative field will be marked as stated above, but the exact level of surgery will be established intraoperatively using imaging.
- In the case of premature infants with delicate skin, marking will not be used to mark the operative site(s) as it may cause permanent tattooing (NSW Department of Health, 2004).
- If a patient refuses to have his/her operative site(s) marked, then exact circumstances relating to the refusal must be documented on the Operation Report and signed by the TMO.

- Where the urgency of surgery precludes marking.

Rationale: *Marking the site makes clear where the surgery is to be performed. Having the surgeon or another designated medical officer of the surgical team mark the site will help ensure that the mark is put at the correct site. Although patients need to corroborate the site as the surgeon marks it, patients are not to mark the site. Marking of non-operative sites may cause confusion and have the opposite of the intended effect. For example, "X" may signify "operate here" to one person and "don't operate here" to another.*

In the VHA series, over 50% of wrong surgeries were due to a 'wrong patient' error. The inclusion of making mid-line procedures and the use of initials rather than arrows may reduce the risk of wrong patient error.

Step 3. **"Identify Patient** on admission to Operating Suite**"** The nurse admitting the patient to the Operating Suite is responsible for this step. Responsibilities include:-

- Asking the patient to state (not confirm) their full name, date of birth, the procedure s/he is having, and the site/side of the procedure.
- Signing and dating that the Ensuring Intended Surgery protocol, which is illustrated in Table 1, has been completed on Surgical Check Sheet.

Exceptions

- If the patient is unable to state his/her name, date of birth and procedure than an appropriate substitute decision maker must be present to state the details and this must be documented in the notes.

Rationale: *Asking the patient to state rather than confirm his/her name helps prevent miscommunication and wrong-patient procedures. Patients who are hard-of-hearing or distracted by illness or other temporary or permanent disability may say "yes" to a name that is not theirs, but it is very unlikely that they will misstate their name and birth date when asked.*

Table 1 – Ensuring Intended Surgery Protocol on Surgical Check Sheet

Mark the site — Yes / No / NA Sign /Date/Time	**Pre-operative** *prior to any ordered pre-medication*	**Identify Patient** on Admission to Operating Suite	**Final Check**
Full name, DOB, & URN matches ID band & records	Yes / No	Yes / No	Yes / No
Tell me in your own words what you are having done today		Answer corresponds with consent form Yes / No	Surgery corresponds with consent form Yes / No
Consent form signed	Yes / No	Yes / No	Yes / No
Correct surgical site(s) marked	Yes / No / NA	Yes / No / NA	Yes / No / NA
Prostheses available, if required			Yes / No / NA
Imaging data are correct and properly labelled	Yes / No / NA	Yes / No / NA	Yes / No / NA
	Sign /Date/Time	Sign /Date/Time	Sign /Date/Time

* Table 1 is an example of documenting the steps for the Ensuring Intended Surgery protocol on the Surgical Check Sheet

Step 4. **"Final Check"** The IMO is responsible for this step. Ideally it is best to carry out this step when the patient is awake. However, if this is not possible then the step can be performed post induction of anaesthesia but before prepping and draping. If the anaesthetist is performing the first invasive procedure such as a local anaesthetic block, it is their responsibility to ensure that Step 2 has been done.

Responsibilities in the Final Check include:-

- Ceasing all non-critical activities in the Operating Room and summoning the attention of all staff in the Operating Room.
- Simultaneously checking with the anaesthetist and circulating nurse or instrument nurse, to verify the patient's:-
  - ✓ Correct name and date of birth or URN.
  - ✓ Surgical procedure(s).
  - ✓ Correct marking of surgical site(s).
  - ✓ Prosthesis is available, if required.
  - ✓ Imaging data, if required, are correct and properly labelled.
- Having the surgeon sign contemporaneously that the step has been completed on the Surgical Check Sheet as in Table 1, or through some other official Queensland Health documentation.
- In case of extreme emergency the Final Check may be omitted, which would be documented accordingly.

Rationale: *Verifying the information just prior to commencing surgery, by an assemblage of persons from the surgical team, helps prevent wrong-site surgery. Having members of the surgical team overtly clarify the details demonstrates a clear understanding of the surgery to be performed. Undertaking the check as close to surgery as possible prevents situations occurring that could influence wrong-site surgery. Errors in determining the appropriate site due to lack of availability or improper labelling of images is a real vulnerability and methods to mitigate this vulnerability need to be in place.*

ISSUES RELATED TO ENSURING INTENDED SURGERY

- Failure to comply with Ensuring Intended Surgery policy without good reason, increase the risk of wrong surgery and may lead to disciplinary actions.
- Wilfully neglecting to carry out the protocol may lead to an employee's indemnity being jeopardised, according to the Industrial Relations Policies 3.8-4 http://www.health.qld.gov.au/industrial_relations/Masters/SECT3/irm3_8_4.pdf for medical practitioners and 3.8-3 http://www.health.qld.gov.au/industrial_relations/Masters/SECT3/irm3_8_3.pdf) for other employees of Queensland Health.
- If wrong-side surgery does occur then procedures stated in the Incident Management Policy No. 23360 (http://qheps.health.qld.gov.au/hssb/risk/im/home.htm) must be followed. That is, necessary action should be undertaken to minimise the effect of the wrong surgery and ensure that the patient obtains the necessary surgery. The incident is then reported as a sentinel event and a Root Cause Analysis (RCA) is commissioned by the District Manager within 7 working days. A RCA should be conducted in all cases to determine causality.
- Even though this policy specifically relates to invasive surgery, the protocols herein are applicable to other procedures including chemotherapy and radiotherapy.

Page for poster

GLOSSARY & REFERENCES

Glossary

Anaesthesia: Loss of feeling or sensation and is induced to permit the performance of surgery or other painful procedures.

General: a state of unconsciousness produced by anaesthetic agents and the absence of pain sensation over the entire body.
Local: refers to a regional anaesthesia and includes such procedures as spinals, epidurals, caudal, regional, and retrobulbar blocks.

Integrated Risk Management is the systematic application of the risk management process in all activities undertaken at all levels of the organisation. The term also refers to the integration of clinical and non-clinical risks resulting in a total risk profile and action plan.

Must: Refers to necessity or inevitability.

Prosthesis: An artificial substitute for a malfunctioning or absent human part For example, Richards pin and plate for a fractured neck of femur

Risk Management Context is defining the relationship between Queensland Health and its environment, identifying Queensland Health's strengths, weaknesses, opportunities and threats. The context includes the financial, operational, competitive, political (public perceptions/image), social, client, cultural and legal aspects of Queensland Health's functions.

Risk Management Process is the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.

Sentinel Event: A sentinel event is defined as "...an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." In this particular policy the sentinel events are (1) wrong-site surgery, (2) wrong surgery; and (3) surgery performed on the wrong patient.

Treating Medical Officer refers to a medical officer in the role of a consultant surgeon, surgical registrar, fellow, or Principal House Officer (PHO) who is responsible for the treatment of the patient.

Visiting Medical Officer refers to a consultant surgeon or consultant anaesthetist who works in a part-time position in a Queensland Health facility.

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